HIPAA (Health Insurance Portability and Accountability Act) Project

TRANSACTION CODE DESCRIPTIONS

Transaction Code	Description
270/271: Health Care Eligibility/Benefit Inquiry and Information Response	The eligibility for a health plan transaction (270) is the transmission of an inquiry from a health care provider to a health plan, or from one health plan to another health plan, to obtain any of the following information about a benefit plan for an enrollee: a. Eligibility to receive health care under the health plan. b. Coverage of health care under the health plan. c. Benefits associated with the benefit plan. The eligibility transaction (271) is a response from a health plan to a health care provider's (or another health plan's) inquiry (270) as described above.
276/277: Claims Status Inquiry/Response	This transaction is used by a provider to request the status of the claim received by the payer's system with the 277response returning the status information of that claim.
277/275: Health Care Claim Request for Additional Information and Response	These transactions are not final rule at this time, but can be used, when indicated by trading partner agreement, by health plans to request additional information needed to adjudicate the claim with the 275 being the medium for returning that requested information. The 275 will also be used as a claims attachment to submit with the claim.
277U: Claim Status for Pended Claims	This transaction will be used as a vehicle to report claims that have been received by the payers system, but are pended for review/adjudication.
278: Health Care Services Review Request for Review and Response	The 278 transaction is the vehicle for submitting electronic requests for prior authorization for services and is also used in the response. This can also be used for referral processes, but Washington Medicaid does not do referrals.
820: Payment Order/ Remittance Advice	The 820 transaction is used as the vehicle for transmitting payment information back to Health Plans for premium payments.
824: Application Error Advise	The 824 transaction allows computer-to-computer automated reporting of errors and enables automated response with required data when possible, also reducing processes by weeks
834: Benefit Enrollment and Maintenance	This transaction is used to transmit healthy options enrollment (including new enrollees, terminations, and current enrollees) to the health plans each month.
835: Remittance Advice	The 835 remittance advice is used to report any payment or denial of claims submitted to health plans for payment.
837 P: Health Care Claim: Professional	This transaction is used to electronically transmit a claim used for billing payers for professional health care services.
837 I: Health Care Claim: Institutional	This transaction is used to electronically transmit a hospital claim used for billing payers for hospital claims including inpatient (S), outpatient (M), and Diagnosis Related Grouping (DRG) (R) claims. Washington Medicaid uses this transaction for home health claims as well.
837 D: Health Care Claim: Dental	This transaction is used to electronically transmit a dental claim used for billing payers for dental related services.
997: Functional Acknowledgement	This is a transaction used to electronically transmit an acknowledgement of receipt back to the submitter of a batch that their file was received and was either accepted into the receiver's system or rejected/returned and why.